FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Arymo™ ER Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:	Office Contact:	
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.

Quantity per DAY requested? _____

Select the diagnosis below:

❑ Management of pain severe enough to require daily, around the clock, long-term opioid treatment and for which alternative treatment options are inadequate

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the patient's pain associated with cancer? ❑ **Yes** ❑ **No**

If **yes**, please provide cancer diagnosis: _____

If **no**, does the patient have chronic non-cancer pain? ❑ **Yes** ❑ **No**

Has the patient had prior use of TWO generic opioids? ❑ **Yes** ❑ **No**

If **yes**, please specify:_____

Is there a history of or a potential for drug abuse among the patient or a member of the patient's household? ❑ **Yes** ❑ **No**

Is there documentation of current patient-prescriber opioid treatment agreement? ❑ **Yes** ❑ **No**

Initial authorization (patient new to high dose opioid therapy [morphine equivalent dose 90mg per day or greater]):

Is the patient opioid tolerant as demonstrated by adherence to one of the following regimens for at least one week? ❑ **Yes** ❑ **No**

- 25mg of oral oxymorphone daily
- 30mg of oxycodone daily
- 60mg of oral morphine daily
- 8mg of oral hydromorphone daily

Is the patient opioid tolerant as demonstrated by adherence to an equianalgesic dose of another opioid for at least one week? ❑ **Yes** ❑ **No**

If **yes**, please provide the name, dose, and duration of the medication tried:_____

_____

Has the patient been evaluated for non-opioid prescription pharmacologic treatment prior to initiation of high dose opioid therapy? ❑ **Yes** ❑ **No**

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Continuation (patient continuing high dose opioid therapy [morphine equivalent dose 90mg per day or greater]):

Is the patient tolerating the requested medication appropriately? ❑ **Yes** ❑ **No**

Does the patient have improved functioning? ❑ **Yes** ❑ **No**

Is the patient being treated for substance abuse? ❑ **Yes** ❑ **No**

Has the patient's pain been assessed within the last 6 months? ❑ **Yes** ❑ **No**

Medication history:

List the medications (in the **same class**) the patient has a history of trial and failure, or intolerance to: _____

_____

List the medications (that are **therapeutic equivalent alternatives**) the patient has a history of trial and failure, or intolerance to:

_____

_____

Quantity limit requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:_____

Prescriber Attestation of Medical Necessity:

Does the provider attest that the current medication regimen, exceeding the current cumulative morphine equivalent dose (MED) threshold, is medically required? ❑ **Yes** ❑ **No**

Requests exceeding 7 Day Supply Limit for Opioid Naïve Patients:

Does the provider attest that in his/her clinical judgment, the requested day supply exceeding the current 7 day supply limit is medically necessary? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.